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DATE NOTICE SENT TO ALL PARTIES: May/27/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: posterior lumbar inter-body fusion of L4-5 and L5-S1 with instrumentation, cage placement, and posterior lateral arthrodesis

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Neurological Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that medical necessity for posterior lumbar inter-body fusion of L4-5 and L5-S1 with instrumentation, cage placement, and posterior lateral arthrodesis has not been established.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on XX/XX/XX. The patient had been followed for complaints of low back pain with progressive pain involving the right lower extremity. Prior treatment had included the use of anti-inflammatories as well as tramadol. It is unclear whether there was any prior physical therapy or injections performed. MRI studies of the lumbar spine completed on XX/XX/XX noted mild disc desiccation and facet hypertrophy with disc space narrowing at L4-5 without evidence of stenosis. At L5-S1 there were also degenerative changes without stenosis. No motion segment instability was identified. The patient was being followed by Dr. XX. The updated XX/XX/XX clinical record noted the patient had progressive weakness in the lower extremities with worsening low back pain. The patient's physical examination noted unspecified weakness in the right lower extremity. No other specific findings were identified. Provocative discography was recommended. The proposed lumbar spine fusion was denied by utilization review as it did not meet guideline recommendations as there was no evidence of instability, scoliosis, kyphosis, or tumor formation. It appears that further imaging had been recommended for the patient which was not performed.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for progressively worsening low back and lower extremities complaints. The patient's symptoms and reported weakness in the right lower extremity is not explained by imaging. The patient's last imaging study of the lumbar spine only noted mild degenerative changes at L4-5 and L5-S1. There was no obvious instability or severe spondylolisthesis at either L4-5 or L5-S1. At this time, it is unclear what the patient's pain generator actually is. The records did not include discussion regarding failure of conservative management to include physical therapy and injections. There was also no documentation regarding a pre-operative psychological consult ruling out any confounding issues that could potentially impact post-operative recovery as recommended by guidelines.

As the clinical records submitted for review do not meet guideline or guideline recommendations regarding the requested services, it is this reviewer's opinion that medical necessity for posterior lumbar inter-body fusion of L4-5 and L5-S1 with instrumentation, cage placement, and posterior lateral arthrodesis has not been established and the prior denials remain upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)